Complete Summary

GUIDELINE TITLE

Elbow (acute & chronic).

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Elbow (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jun 11. 158 p. [215 references]

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- June 15, 2005, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): U.S. Food and Drug Administration (FDA) recommended proposed labeling for both the prescription and over the counter (OTC) NSAIDs and a medication guide for the entire class of prescription products.
- April 7, 2005, Non-steroidal anti-inflammatory drugs (NSAIDS) (prescription and OTC, including ibuprofen and naproxen): FDA asked manufacturers of prescription and non-prescription (OTC) non-steroidal anti-inflammatory drugs (NSAIDs) to revise their labeling to include more specific information about potential gastrointestinal (GI) and cardiovascular (CV) risks.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Work-related disorders of the elbow including fracture or dislocation, sprain or contusion, laceration, medial epicondylitis, lateral epicondylitis, olecranon bursitis, ulnar nerve entrapment, and radial nerve entrapment

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Internal Medicine
Orthopedic Surgery

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To offer evidence-based step-by-step decision protocols for the assessment and treatment of workers' compensation conditions

TARGET POPULATION

Workers with occupational disorders of the elbow

INTERVENTIONS AND PRACTICES CONSIDERED

The following interventions/procedures were considered and recommended as indicated in the original guideline document:

1. Activity restrictions/work modifications
2. Acupuncture for short-term treatment of lateral epicondyle pain

3. Chiropractic/manipulation
4. Cold packs
5. Corticosteroid injection for severe epicondylitis
6. Exercise
7. Heat packs
8. Iontophoresis
9. Magnetic resonance imaging (MRI) (see original guideline document for specific indications)
10. Nonprescription medications, including acetaminophen, topical and oral nonsteroidal anti-inflammatory drugs (NSAIDs), aspirin, and ibuprofen
11. Patient education
12. Physical therapy
13. Radiography
14. Returning to work
15. Splinting for cubital tunnel syndrome (see original guideline document for specific indications)
16. Static progressive stretch (SPS) therapy
17. Stretching
18. Surgery for cubital tunnel syndrome (see original guideline document for specific indications)
19. Surgery for level III and IV radial head fractures
20. Tennis elbow band for epicondylitis
21. Total elbow replacement (TER) when strict inclusion criteria are observed
22. Ultrasound (diagnostic)
23. Ultrasound (therapeutic)

The following interventions/procedures are under study and are not specifically recommended:

1. Augmented soft tissue mobilization
2. Autologous blood injection
3. Extracorporeal shockwave therapy (ESWT) using low energy ESWT
4. Platelet-rich plasma
5. Massage
6. Radial shockwave therapy (RSWT)
7. Soft tissue mobilization
8. Splinting for epicondylitis
9. Surgery for epicondylitis
10. Surgery for pronator syndrome
11. Surgery for level II radial head fractures
12. Tests for cubital tunnel syndrome, epicondylitis, and pronator syndrome
13. Ulnar motor nerve conduction velocity test

The following interventions were considered, but are not currently recommended:

1. Biofeedback
2. Botulinum toxin injection
3. Deep transverse friction massage
4. Diathermy
5. Electrical stimulation (E-STIM)
6. Extracorporeal shockwave therapy (ESWT) using high energy ESWT
7. Fatty acid supplements

8. Immobilization as primary treatment
9. Laser treatment/light therapy (LLLT)
10. Magnets
11. Opioids (except for severe cases)
12. Phonophoresis
13. Pulsed electromagnetic field therapy
14. Static progressive stretch therapy (see original guideline document for specific indications)
15. Surgery for olecranon bursitis
16. Surgery for level I radial head fractures
17. Transcutaneous electrical neurostimulation (TENS)

MAJOR OUTCOMES CONSIDERED

- Sensitivity and specificity of diagnostic tests
- Effectiveness of treatment for relief of pain and other symptoms, optimizing healing/function, increasing work, minimizing risk factors that contributed to the injury

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Work Loss Data Institute (WLDI) conducted a comprehensive medical literature review (now ongoing) with preference given to high quality systematic reviews, meta-analyses, and clinical trials published since 1993, plus existing nationally recognized treatment guidelines from the leading specialty societies. WLDI primarily searched MEDLINE and the Cochrane Library. In addition, WLDI also reviewed other relevant treatment guidelines, including those in the National Guideline Clearinghouse, as well as state guidelines and proprietary guidelines maintained in the WLDI guideline library. These guidelines were also used to suggest references or search terms that may otherwise have been missed. In addition, WLDI also searched other databases, including MD Consult, eMedicine, CINAHL, and conference proceedings in occupational health (i.e. American College of Occupational and Environmental medicine [ACOEM]) and disability evaluation (i.e. American Academy of Disability Evaluating Physicians [AADEP], American Board of Independent Medical Examiners [ABIME]). Search terms and questions were diagnosis, treatment, symptom, sign, and/or body-part driven, generated based on new or previously indexed existing evidence, treatment parameters and experience.

In searching the medical literature, answers to the following questions were sought: (1) If the diagnostic criteria for a given condition have changed since 1993, what are the new diagnostic criteria? (2) What occupational exposures or activities are associated causally with the condition? (3) What are the most effective methods and approaches for the early identification and diagnosis of the

condition? (4) What historical information, clinical examination findings or ancillary test results (such as laboratory or x-ray studies) are of value in determining whether a condition was caused by the patient's employment? (5) What are the most effective methods and approaches for treating the condition? (6) What are the specific indications, if any, for surgery as a means of treating the condition? (7) What are the relative benefits and harms of the various surgical and non-surgical interventions that may be used to treat the condition? (8) What is the relationship, if any, between a patient's age, gender, socioeconomic status and/or racial or ethnic grouping and specific treatment outcomes for the condition? (9) What instruments or techniques, if any, accurately assess functional limitations in an individual with the condition? (10) What is the natural history of the disorder? (11) Prior to treatment, what are the typical functional limitations for an individual with the condition? (12) Following treatment, what are the typical functional limitations for an individual with the condition? (13) Following treatment, what are the most cost-effective methods for preventing the recurrence of signs or symptoms of the condition, and how does this vary depending upon patient-specific matters such as underlying health problems?

Criteria for Selecting the Evidence

Preference was given to evidence that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reports a cohort study, whether prospective or retrospective, or (5) The article reports a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

More information about the selection of evidence is available in "Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument" (see "Availability of Companion Documents" field).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Ranking by Type of Evidence

1. Systematic Review/Meta-Analysis
2. Controlled Trial-Randomized (RCT) or Controlled
3. Cohort Study-Prospective or Retrospective
4. Case Control Series

5. Unstructured Review
6. Nationally Recognized Treatment Guideline (from www.guideline.gov)
7. State Treatment Guideline
8. Other Treatment Guideline
9. Textbook
10. Conference Proceedings/Presentation Slides

Ranking by Quality within Type of Evidence

a. High Quality
b. Medium Quality
c. Low Quality

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Work Loss Data Institute (WLDI) reviewed each article that was relevant to answering the question at issue, with priority given to those that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reported a cohort study, whether prospective or retrospective, or (5) The article reported a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

Especially when articles on a specific topic that met the above criteria were limited in number and quality, WLDI also reviewed other articles that did not meet the above criteria, but all evidence was ranked alphanumerically (see the Rating Scheme of the Strength of Evidence field) so that the quality of evidence could be clearly determined when making decisions about what to recommend in the Guidelines. Articles with a Ranking by Type of Evidence of Case Reports and Case Series were not used in the evidence base for the Guidelines. These articles were not included because of their low quality (i.e., they tend to be anecdotal descriptions of what happened with no attempt to control for variables that might effect outcome). Not all the evidence provided by WLDI was eventually listed in the bibliography of the published Guidelines. Only the higher quality references were listed. The criteria for inclusion was a final ranking of 1a to 4b (the original inclusion criteria suggested the methodology subgroup), or if the Ranking by Type of Evidence was 5 to 10, the quality ranking should be an "a."

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Prior to publication, select organizations and individuals making up a cross-section of medical specialties and typical end-users externally reviewed the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary. The recommendations that follow are based on the previous version of the guideline.

Initial Diagnosis

- First visit: with Primary Care Physician MD/DO (100%)
- Determine cause: Initial Evaluation:
    - Determine the type of trauma (e.g., fall, repetitive motion, twisting, etc.).
    - Determine whether the problem is acute, subacute, chronic, or of insidious onset.
    - Determine the severity and specific anatomic location of the pain.
    - Assess the ability of the patient to use the elbow, from no to full ability.
    - Search for any evidence of an open or penetrating wound.
    - Test the range-of-motion of the joint (normal, mild restriction, severe restriction).
    - Search for any evidence of vascular or nerve injury distal to the injury.
    - Determine any present medication.
    - Determine any previous medical history, history of systemic disease, or previous elbow injury or disability, job requirements, and hobbies.
- Initial diagnosis (Refer to the original guideline document for International Classification of Diseases, Ninth Revision [ICD-9] codes):
    - Traumatic (*Go to Fractures and Dislocations*):
        - Fracture or dislocation
    - Other (*Go to Initial Conservative Treatment*):
        - Sprain or contusion
        - Laceration
        - Epicondylitis, medial
        - Epicondylitis, lateral
        - Olecranon bursitis

- Pronator syndrome
- Ulnar nerve entrapment (Cubital tunnel syndrome)
- Radial nerve entrapment

Fracture or Dislocation of Elbow (35% of cases)

- Definitive Evaluation:
  - Search for any evidence of an open wound in the vicinity of the fracture; if there is an open wound, treat for infection and examine for the presence of foreign bodies (visual, x-ray).
  - Perform a clinical examination for deformity, tenderness, or ecchymosis, or associated nerve, neurovascular, or tendon injury. Also look for the inability to perform spontaneous movement of the elbow.
  - Search for any evidence of dislocation and arterial vascular compromise (cold, dusky hand and forearm with loss of sensation). If found, an immediate reduction should take place (prior to x-rays if necessary).
  - X-ray the elbow. Special views should be obtained when necessary.
- Initial Therapy
  - Simple, undisplaced, stable fractures of the elbow can be treated by the primary care physician.
  - Apply a sling and/or a posterior splint with medial and lateral gutter splints. A portion of patients should be converted to a long arm cast after 10 to 14 days.
  - Ice and elevation whenever lying down for the first 72 hours
  - Analgesics and/or nonsteroidal anti-inflammatory drugs for up to two weeks
  - Aspirating the radiohumeral joint and injection of local anesthetic to evacuate hematoma is appropriate to relieve pain in selected cases of radial head fractures.
  - Physical therapy (3 to 6 visits) to teach patient range-of-motion and muscle-strengthening exercises out of the splint should begin as soon as tolerated at two to four weeks.
  - Recheck at seven days, then at two-week intervals until healed. Repeat x-rays at seven days and at two weeks to assure that the fracture has not slipped. X-ray again at five weeks.
  - Complex, displaced, or unstable fractures should be immobilized and referred to an orthopedic surgeon. Compound fractures, when appropriate, should have a tetanus toxoid injection before being referred to a surgeon.
  - Dislocations of the elbow are accompanied by significant ligament injuries. Even if full reduction has been achieved, orthopedic referral is appropriate.

Official Disability Guidelines (ODG) Return-To-Work Pathways - Fracture

Stable, clerical/modified work: 2 days

Stable, manual work: 14 days

Reduction/manipulation, clerical/modified work: 14 days

Reduction/manipulation, manual work: 28 days

Reduction/manipulation, heavy manual work: 42 days

ODG Return-To-Work Pathways - Dislocation

Non-dominant arm, clerical/modified work: 0 days

Non-dominant arm, manual work: 10 days

Non-dominant arm, heavy manual work: 21 days

Dominant arm, clerical/modified work: 7 days

Dominant arm, manual work: 21 days

Dominant arm, heavy manual work: 42 days

(See *ODG Capabilities & Activity Modifications for Restricted Work* under "Work" in the Procedure Summary of the original guideline document)

- Secondary evaluation for patients with persistent symptoms or minimal improvement after six weeks of therapy
    - Review for compliance of the employee and employer to therapy programs and job modifications and restrictions. Also review for insurance company cooperation.
    - Evaluate for delayed union, malalignment, or signs of associated tendon or nerve injury.
    - Promptly refer to an orthopedic surgeon if one of these conditions is found.

Initial Conservative Treatment of Disorders Other than Fractures (65% of cases)

- Definitive Evaluation:
    - Typical symptoms of lateral epicondylitis ("tennis elbow") include pain in the lateral aspect of the elbow with pain or burning radiating to the forearm (and occasionally proximal radiation). With medial epicondylitis ("golfers elbow") the pain is on the inside of the elbow (versus outside of the elbow for tennis elbow). There may be loss of grip strength due to forearm pain with hand grip. Pain is usually insidious in onset but may be provoked by an acute trauma or strain. Initial complaints may be vague, such as a dull forearm ache.
    - Specific attention should be directed towards confirming occupational risk factors, such as repetitive, sustained, or forceful wrist dorsiflexion, power grip, exposure to vibration, repetitive extended elbow reach with forceful pulling, and repetitive pronation and supination of the forearm against resistance.

- Rule out non-occupational activities that could be causing or aggravating the condition, such as activities that require gripping or hyperextending the wrist.
- Olecranon bursitis may be secondary to systemic illness.
- A physical examination should be performed with documentation of the following findings:
    - Inspection for deformity, swelling, or erythema
    - Provocative maneuvers, such as the presence or absence of pain with resisted dorsiflexion of the wrist, passive wrist flexion with the elbow in full extension, resisted supination of the forearm, and Tinel's sign
    - Range of motion: elbow flexion and extension, pronation and supination, wrist flexion and extension. Note any flexion contracture deformity of the elbow.
    - Palpation: Document the presence or absence of the following: elbow deformity, tenderness, heat, or crepitus (including olecranon process and medial epicondyle). Also check the forearm for deformity, heat, or tenderness.
    - Muscle strength testing of the entire upper extremity should be performed as relevant.
    - Appropriate distal extremity exam should include neurological testing. A routine examination of the shoulder, neck, wrist, and hand (palpation, range of motion, strength testing) should be performed.
    - A differential diagnosis should be considered at this point, such as radiculopathy or shoulder pathology with referred pain.
- As a rule, the diagnosis of elbow problems does not require an imaging study.
- Appropriate laboratory studies should be considered if there is evidence of an infectious or diffuse inflammatory process as a contributing or causative factor.
- Nerve conduction studies may be indicated for elbow problems associated with neurological deficits.
- Aspiration of the olecranon bursa is not routinely indicated unless there is suspicion of infection or metabolic disease.

- Initial Treatment
    - The purpose of the initial treatment is to reduce symptoms, optimize healing/function, and increase work, with appropriate modifications to minimize the risk factors that contributed to the injury.
    - All injured workers should receive instruction concerning the nature of their condition, its risk factors, preventive measures, and goals of initial therapy. The injured worker should be instructed on how to eliminate or modify any aggravating non-occupational activities and sports during treatment.
    - Work restrictions or modifications that reduce the injured worker's exposure to the etiologic or aggravating activity are of central importance. Examples of such restrictions include preclusion from or reduction in time performing tasks requiring repetitive, sustained, or repetitive forceful wrist or hand activities, repetitive elbow motion, prolonged elbow positioning, or prolonged exposure to vibration.
    - Nonsteroidal anti-inflammatory agents (NSAIDs) can be used. Acetaminophen is an analgesic that may be used as an adjunct or alternative to NSAIDs.

- Physical treatments and passive modalities: If there is no improvement after 2 weeks, the treatment should be modified. Use of thermal modalities in conjunction with physical treatment may be useful. Physical treatments for pain management, splinting, and/or functional retraining and instruction in a graded exercise program. Appropriate exercises may include, but are not limited to 1) gentle muscle stretching, 2) flexibility, and 3) graduated strengthening. Care should be taken while incrementing exercises so that the condition is not aggravated. Appropriate manual therapies may include manipulation, or joint or soft tissue mobilization, supplemented by physical modalities and exercise.
- Acupuncture: Use of acupuncture in the first 4 weeks of treatment as a part of an overall treatment plan.
- Protective devices: The use of an elbow and/or wrist support for immobilization may be indicated for a brief period. The use of a splint at work must be carefully considered, as it may put the injured worker at risk for further musculoskeletal injury by forcing the adoption of awkward compensatory postures. A forearm strap can be aggravating in the acute stage, so its use should be individualized. It is contraindicated in the presence of nerve compression symptoms. Night splinting may be indicated for nerve entrapment syndromes.
- Local corticosteroid injection: Local corticosteroid injections of the myofascial areas or bursae may be appropriate, especially if the pain is moderate to severe. Before the injection, it is important to be aware that the olecranon bursa may be the site of infection. In such an instance, a steroid injection would be contraindicated. Refer to an orthopaedic surgeon if infection is present.
- Surgery is rarely indicated.

- Secondary Assessment
  - A reconsideration of the initial diagnosis is necessary at this stage, and a differential diagnosis should be reviewed: cervical radiculopathy, shoulder pathology with referred pain and nerve entrapment.
  - Diagnostic imaging: Radiographic studies of the elbow and forearm may be considered if, on re-evaluation, the physician suspects morphologic pathology. The use of magnetic resonance imaging (MRI) and arthrography is rarely indicated except for the evaluation of intraarticular pathology.
  - Laboratory studies: Laboratory studies may be performed if there is evidence of an infectious or diffuse inflammatory process as a contributing pathology.
  - Electromyography/nerve conduction studies (EMG/NCS) to rule out other conditions: Electrodiagnostic studies should be considered if there is clinical evidence of nerve entrapment or cervical radiculopathy as alternative diagnoses.
  - Surgical referral: Orthopaedic surgical consultation may be recommended after failure of conservative treatment and indication of a surgically correctable condition.

ODG Return-To-Work Pathways – Sprain
Moderate, clerical/modified work: 4 days

Moderate, manual work: 21 days

Severe, clerical/modified work: 7 days

Severe, manual work: 35 to 42 days

ODG Return-To-Work Pathways - Contusion

Superficial contusions: 0 days

Deep contusions, clerical/modified work: 5 days

Deep contusions, manual work: 21 days

ODG Return-To-Work Pathways - Laceration

Minor: 0 days

Major, clerical/modified work: 3 days

Major, manual work: 8 days

ODG Return-To-Work Pathways - Epicondylitis, Medial

Without surgery, modified work: 0 days

Without surgery, regular manual work: 7 days

Without surgery, heavy manual work: 42 days

ODG Return-To-Work Pathways - Epicondylitis, Lateral

Without surgery, modified work: 0 days

Without surgery, regular manual work: 7 days

Without surgery, heavy manual work: 42 days

Without surgery, heavy manual vibrating work, if cause of disability: indefinite

With surgery (rare), modified work, non-dominant arm: 6 days

With surgery (rare), modified work, dominant arm: 21 days

With surgery (rare), regular work, non-dominant arm: 28 days

With surgery (rare), regular work, dominant arm: 42 days

Acupuncture (3 to 6 treatments): 7 to 21 days

ODG Return-To-Work Pathways - Olecranon Bursitis

Without surgery, modified work: 0 days

Without surgery, regular manual work: 4 days

Without surgery, heavy manual work: 35 days

ODG Return-To-Work Pathways - Ulnar Nerve Entrapment

Without surgery, modified work: 0 days

Without surgery, regular work: 14 days

With surgery, modified work: 14 days

With surgery, regular work, non-dominant arm: 21 days

With surgery, regular work, dominant arm: 49 days

ODG Return-To-Work Pathways - Radial Nerve Entrapment

Diagnostic testing: 0 days

Treatment, clerical/modified work: 14 days

Treatment, manual work: 42 days

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

During the comprehensive medical literature review, preference was given to high quality systematic reviews, meta-analyses, and clinical trials over the past ten years, plus existing nationally recognized treatment guidelines from the leading specialty societies.

The heart of each Work Loss Data Institute guideline is the Procedure Summary (see the original guideline document), which provides a concise synopsis of effectiveness, if any, of each treatment method based on existing medical evidence. Each summary and subsequent recommendation is hyper-linked into the studies on which they are based, in abstract form, which have been ranked, highlighted and indexed.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

These guidelines unite evidence-based protocols for medical treatment with normative expectations for disability duration. They also bridge the interests of the many professional groups involved in diagnosing and treating disorders of the elbow.

POTENTIAL HARMS

- The use of a splint at work must be carefully considered, as it may put the injured worker at risk for further musculoskeletal injury by forcing the adoption of awkward compensatory postures. A forearm strap can be aggravating in the acute stage so its use should be individualized.
- Steroid injection has been associated with an increase in reported pain for the first 24 hours of treatment.
- Topical Nonsteroidal anti-inflammatory drugs have been reported to occasionally cause mild skin rashes.

CONTRAINDICATIONS

CONTRAINDICATIONS

- A forearm strap is contraindicated in the presence of nerve compression symptoms.
- If the olecranon bursa is infected, a steroid injection would be contraindicated.
- Contraindications for total elbow replacement include Type II or III Gustilo-Anderson open fractures (primary irrigation and debridement); preexisting infection, open wounds; younger, high-demand, or noncompliant patient; paralysis of the biceps muscle.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The Treatment Planning sections outline the most common pathways to recovery, but there is no single approach that is right for every patient and these protocols do not mention every treatment that may be recommended. See the Procedure Summaries (in the original guideline document) for complete lists of the various options that may be available, along with links to the medical evidence.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Elbow (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jun 11. 158 p. [215 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 (revised 2007 Jun 11)

GUIDELINE DEVELOPER(S)

Work Loss Data Institute - Public For Profit Organization

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Editor-in-Chief, Philip L. Denniston, Jr. and Senior Medical Editor, Charles W. Kennedy, MD, together pilot the group of approximately 80 members. See the ODG *Treatment in Workers Comp* Editorial Advisory Board.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

There are no conflicts of interest among the guideline development members.

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

GUIDELINE AVAILABILITY

Electronic copies of the updated guideline: Available to subscribers from the Work Loss Data Institute Web site.

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Background information on the development of the Official Disability Guidelines of the Work Loss Data Institute is available from the Work Loss Data Institute Web site.
- Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument. Available to subscribers from the Work Loss Data Institute Web site.

PATIENT RESOURCES

The following is available:

- Appendix B. ODG Treatment in Workers' Comp. Patient information resources. 2006.

Electronic copies: Available to subscribers from the Work Loss Data Institute Web site.

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material

and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 13, 2004. This NGC summary was updated by ECRI on March 28, 2005, January 3, 2006, November 9, 2006, March 29, 2007, and August 16, 2007.

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